



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF: [REDACTED]

BORN: 2/23/12

DATE OF INCIDENT: 12/25/12

DATE OF ORAL REPORT: 12/26/12

FAMILY NOT KNOWN TO:

Northampton County Children, Youth & Families

REPORT FINALIZED ON: 4/24/13

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.

(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.

(23 Pa. C.S. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with ChildLine for investigation.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Northampton County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child (VC)	2/23/12
[REDACTED]	Mother (MO)	[REDACTED]/92
[REDACTED]	Father/Alleged Perpetrator (AP)	[REDACTED]/74
[REDACTED]	Maternal Grandmother (MGM)	[REDACTED]/60
[REDACTED]	Maternal Aunt (MA)	[REDACTED]/99

Notification of Child (Near) Fatality:

On 12/25/12 Lehigh County Children and Youth Services (LCCYS) received a referral [REDACTED] stating that the VC was taken to [REDACTED] Hospital [REDACTED]. The VC was examined. [REDACTED]

On December 26, 2012 the Northeast Regional Office (NERO) of Children, Youth and Families received the report of the near fatality.

Summary of DPW Child (Near) Fatality Review Activities:

The NERO Human Services Program Representative (HSPR) met with the Northampton County Children Youth and Families (NCCYF) child protective services supervisor and caseworker to discuss this case. The NERO HSPR had obtained and reviewed the entire file regarding this family. The NERO also participated in the internal fatality review team meeting on February 6, 2013.

Summary of Services to Family:

NCCYF provided parenting education, casework services, and random urine screens to the father during the child abuse investigation. They offered the mother random urine screens during the child abuse investigation, but she refused.

Children and Youth Involvement Prior to Incident:

The family was not known to NCCYF prior to the incident.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 12/25/12 LCCYS received a near fatality report from ChildLine regarding the VC. The report stated that upon arrival at the hospital, the VC's mother reported that she picked the VC up from a visit with his father. At that time, she noticed a bump on the VC's head. The VC's father reported the VC climbed under a coffee table and bumped his head. However, the VC's mother became concerned because the VC was lethargic and vomited; as a result she transported the VC to the hospital. Upon arrival to the hospital, the VC was conscious but limp in the VC's mothers' arms. A CT scan revealed a brain bleed. The treating physician believes the VC's father's account is not consistent with the VC's injury. The VC was admitted to the hospital and the treating physician certified the VC to be in critical condition.

On 12/26/12 LCCYS received a supplemental report that stated that when the mother picked the VC up from his father's house on 12/25/12, the VC was lethargic and gray. Mother took the VC [REDACTED]. The exam noted small bruising on the VC's back above the waistline, visible abrasions and bruises on his right forearm, and abrasions on middle left ring finger. [REDACTED]

On 12/26/12 an investigator from LCCYS conducted a 24 hour safety assessment on the VC. The investigator and the VC's mother developed a safety plan. The safety plan stated that the alleged perpetrator (AP) the victim child's father would not have any contact with the VC until further assessment. During the conversation with VC's mother it was found that the AP resides in Northampton County. It was also found that the AP has 5 other children and is the primary caregiver for two of the children. Therefore, the report was transferred to NCCYF.

On 12/26/12 NCCYF CPS investigator contacted the VC's mother. The mother informed the investigator that the VC is doing well. The mother was not sure when VC would be discharged from the hospital.

On 12/26/12 NCCYF investigator conducted an unannounced home visit to the AP's home (VC's father) to assess the safety of the other children in the home;

father was not home. The investigator left a message for father requesting a call back. Later on that day the AP contacted the investigator. The investigator informed the AP of the allegations. A safety plan was developed for AP and his children. The children, who he is the primary caregiver for, will stay with their paternal grandmother until further assessment

On 12/28/12 NCCYF investigator contacted [REDACTED] to determine the age of the VC's injuries. [REDACTED] was unable to provide an age of the VC's injury.

On 1/18/13 NCCYF investigator conducted an announced home visit at the VC's home. No issues or concerns were reported.

On 1/30/12 NCCYF investigator interviewed the AP. The AP provided a timeline of the activities that occurred prior to and during the VC's visit at his home. The victim child went to visit his father from December 22 to December 25th, 2012. The victim child had a cold and was teething during this time. The mother informed the AP that the victim child fell down the steps at mother's home prior to visiting AP. AP noticed that the victim child was sleeping a lot. AP reported that on 12/23/2012 the victim child fell out of the bed. The victim child's head was stuck between the bed and the table. AP reported that he picked up the victim child by his armpit. AP had difficulty pulling the victim child up, so he moved the table. AP reported that the victim child had scratches on the right side of his head that looked like brush burns. AP reported that he soothed the victim child and he went back to sleep after 10-15 minutes. AP reported that the victim child slept for the rest of the night. The AP reported that the victim child did not appear to be himself on 12/24/12. The victim child was not as active as usual. The victim child vomited his cereal and formula. On 12/25/12, the victim child did not feed well and he was not as active as usual. The victim child returned to his mother's care on 12/25/12.

On 2/4/13 NCCYF investigator interviewed the mother. The mother provided a timeline of activities that occurred leading up to and after VC's visit at the AP's home. The victim child went to visit his father from December 22 to December 25th, 2012. The victim child had a cold and was teething. On 12-25-12, the victim child returned to his mother's care. The mother observed the child to have poor coloring, his lips were blue, and she was concerned. The child vomited and was lethargic. Child was taken to the hospital for an examination and was found to have a brain bleed. He was certified to be in critical condition and admitted to [REDACTED].

On 2/22/13 the NCCYF investigator determined that the allegations did not meet the criteria for physical abuse as defined by the CPSL Chapter 6303. The victim sustained serious injuries, however, there is no evidence that the injuries were non accidental. Therefore, the report received an unfounded status.

Current Case Status:

The VC remains in the care of his mother. The VC lives with his mother, maternal grandmother, and maternal aunt in Lehigh County, PA. [REDACTED] NCCYF sent a referral to LCCYS for further assessment. The VC has sporadic contact with his father.

The father has a total of 6 children. The father has two children to whom he is the primary caregiver for, [REDACTED] NCCYF has accepted the father for ongoing services. The father is participating in parenting education, casework services, and random urine screens at this time.

The father has minimal contact with his other 4 children.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:

- Strengths: Northampton County Children, Youth and Families and Lehigh County Children and Youth Services collaborated throughout the investigation. The father resides in Northampton County where the incident occurred; the mother resides in Lehigh County.
- Deficiencies: None reported
- Recommendations for Change at the Local Level: None reported
- Recommendations for Change at the State Level: None reported

Department Review of County Internal Report:

NERO received the county report on 3/15/13. NERO provided written feedback and requested changes to the document on 4/11/13. The NERO investigation consisted of a review of the CPS file, interviews with Northampton County Department of Human Services, Children, Youth and Families Division staff and participation in several meetings with Northampton CYF staff regarding the status of this investigation. NERO agrees with the county's finding.

Department of Public Welfare Findings:

- County Strengths: The LCCYS and NCCYF effectively communicated regarding the reassignment of the CPS investigation. The NCCYF assessed the safety and risk of the VC as required. The agency was also able to connect the parents to appropriate resources to assist with parenting.

- County Weaknesses: Although, the agency held an Act 33 meeting, the meeting was not held within 30 days of the oral report.
- Statutory and Regulatory Areas of Non-Compliance: The agency will be cited for non compliance of Act 33 of 2008.

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Department of Public Welfare Recommendations:

- Continue to collaborate with LCCYS to ensure both agencies are adhering to their inter county transfer of cases mutual agreement.
- The agency should consider scheduling Act 33 meetings as soon as report is received to ensure the meetings are held within 30 days of the oral report.